

# FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

## ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan

P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150

334-517-7000 or 877-517-0020

Web site: [www.rsa-al.gov](http://www.rsa-al.gov)



In lieu of completing and mailing this form, you can make your changes online using the Web site above.

### PEEHIP Subscriber Information

*Name must be entered as shown on your Social Security card.*

Social Security Number ____-____-____		First Name	Middle Name/Initial	Last Name	
Mailing Address			City	State	ZIP Code
Date of Birth ____/____/____		Home Phone ____-____-____		Work Phone ____-____-____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed					

### Reason for Status Change

I certify that I have incurred the following change in status:

- |   |  |
|---|--|
| <input type="checkbox"/> Marriage                   | <input type="checkbox"/> Significant change in medical benefits or premiums  |
| <input type="checkbox"/> Marriage of dependent      | <input type="checkbox"/> Termination of spouse/dependent employment          |
| <input type="checkbox"/> Birth of a child           | <input type="checkbox"/> Commencement of spouse/dependent employment         |
| <input type="checkbox"/> Adoption of a child        | <input type="checkbox"/> Taking leave under the Family and Medical Leave Act |
| <input type="checkbox"/> Legal custody of a child   | <input type="checkbox"/> Medicare/Medicaid entitlement                       |
| <input type="checkbox"/> Divorce/annulment          | <input type="checkbox"/> Unpaid Leave of Absence                             |
| <input type="checkbox"/> Death of spouse/dependent  | <input type="checkbox"/> Short plan year                                     |
| <input type="checkbox"/> Dependent loss of coverage |  |

**Date qualifying event occurred (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

*Note: PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

### Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request:

*Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.*

- New Annual Election Amount \$ \_\_\_\_\_ × 12 months = \$ \_\_\_\_\_ Annual Amount  
Maximum amount cannot exceed \$5,000 and the minimum annual amount is \$120.
- Stop Payroll Deductions

### Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested:

*Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.*

- New Annual Election Amount \$ \_\_\_\_\_ × 12 months = \$ \_\_\_\_\_ Annual Amount  
Maximum amount cannot exceed \$5,000 if single or married filing a joint return, \$2,500 if married filing separate returns. The minimum annual amount is \$120.
- Stop Payroll Deductions

### PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_